Instructions for Completing Form FA-17

(the Adult Day Health Care (ADHC) Prior Authorization Request)

Use the following instructions to complete and submit the Adult Day Health Care Prior Authorization Form (FA-17) to HP Enterprise Services. Form FA-17 must be submitted for all Medicaid-eligible recipients (1) prior to admission into Adult Day Health Care or (2) when the individual becomes Medicaid eligible (Retro-Eligibility Authorization). All Adult Day Health Care services require prior authorization.

1. Complete the "Date of Request" field with the date the form is faxed to HP Enterprise Services.

2. Indicate the type of authorization you are requesting.

   - Check "Initial/New" to request a new Medicaid payment authorization. You should request an Initial/New authorization when a recipient begins attending the ADHC facility or when Medicaid becomes the primary pay source for the recipient.
   - Check "Continuing Services" when the expiration date of a previously authorized period is near and the individual requires ongoing services. (There is no break between an authorized end date and the new ongoing date.)
   - Check "Interim" when the frequency of prior authorized services needs to be changed. For example, ADHC attendance increases from two times weekly to three times weekly.
   - Check "Retro-Eligibility" when requesting a retroactive authorization. You should request a Retro-Eligibility authorization when an individual becomes eligible for Medicaid during or after the course of treatment. If you check this box, you must also enter the date on which Medicaid payment should begin in the "Services Requested" section of this form (bottom of page 2).

3. Complete the "PROVIDER INFORMATION" section.

   a) Enter the name of the ADHC facility requesting the authorization and the provider's name in the "Name" field.

   b) Enter the ADHC provider's 10-digit NPI. Do not include spaces, hyphens, etc.

   c) Next, enter the telephone number, fax number and mailing address of the ADHC facility.

4. Complete the "RECIPIENT INFORMATION" section.

   a) Enter the recipient's last name, first name and middle initial.

   b) Enter the recipient's date of birth and Recipient ID.

   c) Verify that the recipient lives in an independent living situation by checking the box and entering the recipient's mailing address. A recipient is not eligible for ADHC services if they reside in
   (1) a State licensed facility, e.g., a Group Care or Assisted Living facility or (2) a residential facility where services similar to Adult Day Health Care services are a requirement for licensure, or the facility is reimbursed for similar services by Medicaid or another State agency.

5. Complete the "MEDICAL HISTORY" section with as much detail as possible.

   a) Indicate up to three (3) known diagnoses and ICD-9 codes that may justify the recipient's admission to ADHC. Do not use short-term resolving diagnoses such as: bronchitis, urinary tract infection, pneumonia, dehydration, and diarrhea.

   b) List all pertinent medications.

6. Complete Section 1.

    a) Check “Yes” or “No” to indicate whether the recipient is able to safely self-administer any medications listed above.

    b) If the recipient is not able, indicate what their barriers are (e.g., poor eyesight, forgetful, unable to open bottles).

7. Complete Section 2.

    a) Check all of the items listed that pertain to the recipient’s care needs including any special Durable Medical Equipment (DME) needs.

    b) On the blank line, enter details to describe the frequency and duration of treatments, the stage/grade/size/location of any wounds and any other special needs of the recipient.

8. Complete Section 3 (the “Activities of Daily Living (ADL)” section) by checking the appropriate column beside each activity:

    - Independent (Self Care): Place a check in this column if the individual does not require assistance to complete the activity or completes the activity independently with the use of an adaptive device(s).
    - Supervise or Assist: Enter an "S" if supervision is needed for this activity. Enter an "A" if assistance is needed for this activity.
    - Total Dependent: Place a check in this column if the individual is totally dependent on caregivers to provide or complete the activity for them. Use the Comments box to clarify each line and to record any appliances/rehab devices used. Some examples are: needs clothes laid out and supervision while dressing, in restorative aide feeding program, bowel and bladder training program, uses transfer board, self feeds with tray set-up, uses adaptive eating utensils, can wash upper portion of body independently and needs assistance to wash back and feet. If the individual is incontinent, but performs their own peri-care, etc., check the “Incontinent” box in the Activities column and also place a check in the Independent (Self Care) column. In the Comments column of the "Eating/Feeding" activity, indicate if the person is able to prepare/cook their own meals, or if they require meal preparation.

9. On the top of Page 2, enter the individual’s full name and Recipient ID.

10. Complete Sections 4 and 5.

    a) Check all boxes that pertain under "Need for Supervision” and “Instrumental Activities of Daily Living (IADL)” areas.

    b) Use the General Comments line to expand on any topic in these sections.

11. Complete the “SERVICES TO BE PROVIDED BY ADHC” section.

    a) Check all nursing services and non-medical services that are to be provided by the ADHC facility.

    b) When indicated, describe specific treatments/therapies, specialized diets, the frequency and duration of the service and the individual who will perform the service.

    c) Describe a rehabilitative goal that is being, or will be worked on, to maintain and/or improve the recipient’s level of functioning or to lessen any decline in functioning due to disease and/or the aging process. For example, a recipient with a recent Cerebrovascular Accident (CVA) and left

sided weakness will ambulate with assistance three times a week to maintain and/or improve his/her level of independence.

d) Current physician's orders must be attached when submitting the authorization request to HP Enterprise Services. Approval is dependent upon medical necessity. Check the box to indicate that the physician's orders are attached.

12. Complete the "SERVICES REQUESTED" section.

a) Enter the total number of units you are requesting per week (1 unit equals 15 minutes).

Your authorization request must reflect the recipient's projected schedule. For example, if a recipient plans to attend the ADHC facility 6 hours per day on Monday, Wednesday and Friday and 3 hours per day on Tuesday and Thursday of the same week, calculate the requested units per week as follows:

Remember: 1 hour = 4 units (15 minutes per unit)

The recipient attends the ADHC facility 6 hours per day on Monday, Wednesday and Friday: 6 hours per day x 4 units per hour = 24 units for Monday, 24 units for Wednesday and 24 units for Friday.

The recipient attends the ADHC facility 3 hours per day on Tuesday and Thursday of the same week: 3 hours per day x 4 units per hour = 12 units for Tuesday and 12 units for Thursday.

Add the units for all of the days:	Monday	24
	Tuesday	12
	Wednesday	24
	Thursday	12
	Friday	+ 24
	Total for the week:	96 units

b) Enter the recipient's projected attendance schedule. Include the days and times that the recipient plans to attend the ADHC facility each week (e.g., Tuesday and Thursday, 8am – 1pm).

c) Next, enter the begin and end dates of services that you are requesting. If you are requesting a Retro-Eligibility Authorization, enter the past date on which you are requesting Medicaid payment to begin. Please note that the recipient must have been determined eligible retroactively for this date of service.

d) Enter the name and professional title of the person completing this form. Also enter the person's contact information and the date on which the form was completed.

e) On the "Additional Comments" lines, enter any additional information to be considered which may be helpful in determining the appropriateness of Adult Day Health Care services. This area should be used to provide information regarding social history, current living environment and family (or other) support systems available to the recipient. Include what prompted the recipient's need for ADHC and the anticipated length of services. Indicate if the recipient has potential for risk of injury, or would be a danger to self or others without ADHC services. If additional space is needed, please attach a separate sheet. Be sure to include the recipient's name on the attachment.

Additional Notes

Submitting Complete Information

If insufficient information is provided to authorize approval the prior authorization request, the ADHC facility must provide the needed information within 24 hours upon request of HP Enterprise Services. Failure to comply will result in a technical denial due to provider non-compliance.
When complete information is submitted, HP Enterprise Services makes a determination within five business days.

Retro-Eligibility Authorization Requests

When retroactive authorization is required because an individual becomes eligible for Medicaid during or after the course of treatment, the recipient's record must be submitted in addition to the ADHC Prior Authorization Request Form (FA-17) within ninety (90) days from the date that the recipient was determined eligible to receive Medicaid benefits (also called the "Date of Decision" or "DOD"). The recipient's record must include (1) physician's orders, (2) care plans, and (3) progress notes for the retro-active time period.

When complete information is submitted, HP Enterprise Services will make a determination within thirty (30) days. Failure to submit a prior authorization request containing the required information within ninety (90) days from the date of retro-eligibility determination will result in a technical denial due to provider non-compliance.

Authorization Time Limits

ADHC services may be approved for a maximum of six months at a time. With the exception of recipient retro-eligibility determination, retroactive authorization is prohibited.

Determination and Notification

Upon completion, submit this form to HP Enterprise Services. HP Enterprise Services will make a determination and notify the requestor by telephone with an Authorization Number. After determination, a Pre-Authorization Notification is mailed to the requestor. If it is determined the individual did not meet ADHC criteria, the requestor will be notified and a Notice of Decision (NOD) will be mailed to the recipient.